(For Office Use Only)
Client Name (Last, First, M.I.): _____ Date of Birth: _____/_____/_____
Facility: _____

(vers. 10.2008)

Idaho Women's Health Check
Abnormal Breast Diagnostic Follow-up

IDAHO DEPARTMENT OF HEALTH & WELFARE

1. Breast Imaging

Additional Mammographic Views? ☐ Yes ☐ No

Ultrasound? ☐ Yes ☐ No

Results *(check only one)*
- ☐ 1 Negative
- ☐ 2 Benign
- ☐ 3 Probably Benign—*STFU required*
- ☐ 4 Suspicious Abnormality (consider biopsy)
- ☐ 5 Highly Suggestive of Malignancy
- ☐ 0 Incomplete

Date
(____/____/_____)

Facility:
_____

Recommended follow-up covered by WHC:
- ☐ Follow Routine Screening Schedule
- ☐ Short Term Follow-up _____
- ☐ Surgical Consultation
- ☐ Fine Needle Aspiration
- ☐ Biopsy
- ☐ CBE by Consult

1a. Final Imaging Outcome: *(check only one)* **Date: (____/____/_____)**
- ☐ BI-RADS 1
- ☐ BI-RADS 2
- ☐ BI-RADS 3
- ☐ BI-RADS 4
- ☐ BI-RADS 5
- ☐ Unsatisfactory
- ☐ Additional Imaging Pending

2. Surgical Consultation ☐ Yes ☐ No

Consult Outcome
(check only one)
- ☐ No intervention at this time
- ☐ Core Biopsy
- ☐ Fine Needle Aspiration

Date:
(____/____/_____)

Provider:
_____

Recommended follow-up covered by WHC:
- ☐ Follow Routine Screening Schedule
- ☐ Short Term Follow-up _____
- ☐ Additional Mammographic Views
- ☐ Ultrasound
- ☐ Fine Needle Aspiration
- ☐ Biopsy

3. Consultant-Repeat CBE ☐ Yes ☐ No

Consult/CBE Results *(check only one)*
- ☐ Normal/Benign/Fibrocystic
- ☐ Discrete palpable mass (suspicious for cancer)
- ☐ Nipple/areolar scaliness
- ☐ Bloody or serous nipple discharge
- ☐ Skin dimpling or retraction

Date:
(____/____/_____)

Provider:
_____

Recommended follow-up covered by WHC:
- ☐ Follow Routine Screening Schedule
- ☐ Short Term Follow-up _____
- ☐ Additional Mammographic Views
- ☐ Ultrasound
- ☐ Surgical Consultation
- ☐ Fine Needle Aspiration
- ☐ Biopsy

4. Fine Needle/Cyst Aspiration ☐ Yes ☐ No

Results
(check only one)
- ☐ No fluid/tissue obtained
- ☐ Not suspicious for cancer
- ☐ Suspicious for cancer

Date:
(____/____/_____)

Provider:
_____

Recommended follow-up covered by WHC:
- ☐ Follow Routine Screening Schedule
- ☐ Short Term Follow-up _____
- ☐ Additional Mammographic Views
- ☐ Ultrasound
- ☐ Surgical Consultation
- ☐ Biopsy
- ☐ CBE by Consult

5. Tissue Biopsy/Lumpectomy ☐ Yes ☐ No

Results *(check only one)*
- ☐ Normal Breast Tissue
- ☐ Ductal Carcinoma *in situ*
- ☐ Lobular Carcinoma *in situ*
- ☐ Invasive Breast Cancer
- ☐ Atypical Ductal Hyperplasia (ADH)
- ☐ Hyperplasia
- ☐ Other benign changes

Date:
(____/____/_____)

Provider:
_____

Recommended follow-up covered by WHC:
- ☐ Follow Routine Screening Schedule
- ☐ Short Term Follow-up _____
- ☐ Obtain Treatment—*apply for BCC Medicaid separately*

6. Were any other breast procedures performed? ☐ Yes _____ ☐ No

7. Were any imaging or diagnostic procedures funded by Women's Health Check? ☐ Yes ☐ No

8. Diagnostic Work-up Status

(check only one)
- ☐ Pending
- ☐ Work-up complete
- ☐ Lost to follow-up
- ☐ Work-up refused

Additional Comments:
_____
_____
_____

9. Final Diagnosis

Date: ____/____/_____

(check only one)
- ☐ Breast Cancer not diagnosed
- ☐ Ductal Carcinoma *in situ*
- ☐ Lobular Carcinoma *in situ*
- ☐ Invasive Breast Cancer
- ☐ Other _____

Additional Comments:
_____

10. Treatment Information

(to be completed if cancer is diagnosed)

☐ Treatment started……Date: ____/____/_____

- ☐ Treatment pending*
- ☐ Lost to follow-up*
- ☐ Treatment not needed*

*Date: ____/____/_____

Additional Comments:
_____
_____